Client ID: _____

Women's Health Outcome Summary

Admission ID: _____

Client's name *(first, middle, last)*: _____ Maiden name: _____

Client alias: _____ Alias Client ID: _____ Birth date: ____/____/____

Street address: _____ Apt# _____

City: _____ State: _____ Zip code: _____

Cell phone: _____ Alternate phone: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Discharge date: _____/_____/_____

Primary Payment Source: *(enter option from payment source table below)* _____

Payment source:
(check all that apply)

☐ Medicare	☐ private insurance	☐ uninsured
☐ Medicaid/Title XIX	☐ self-pay/sliding scale	☐ other specify _____
☐ presumptive eligibility	☐ Title V	

Does client have a primary medical care provider? (medical home) ☐ yes ☐ no ☐ unknown

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

	Name	Date
Outcome form completed by:		
Data entered by:		
Quality assurance inspection:		